

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF CALIFORNIA

VABLIN KOJIMA,

Plaintiff,

v.

BLUE CROSS AND BLUE SHIELD OF
ALABAMA, et al.,

Defendants.

Case No.: 14-cv-1957-JLS-DHB

**ORDER (1) DENYING PLAINTIFF'S
CONTINUANCE MOTION; (2)
DENYING PLAINTIFF'S MOTION
FOR SUMMARY JUDGMENT; AND
(3) GRANTING DEFENDANTS'
MOTION FOR SUMMARY
JUDGMENT**

(ECF Nos. 41, 43, 53)

Presently before the Court are Plaintiff's Cross-Motion for Summary Judgment, ("Pl.'s MSJ") (ECF No. 41) and corresponding support and opposition briefs; Defendants Blue Cross and Blue Shield of Alabama's ("BCBS") and Vulcan Materials Company Group Health Care Plan's (together, "Defendants") Motion for Summary Judgment, ("Defs.' MSJ") (ECF No. 43) and corresponding support and opposition briefs; Defendants' Supplemental Brief re Pending Summary Judgment Motions, ("Defs.' Suppl. Br.") (ECF No. 55); and Plaintiff's *Ex Parte* Motion to Continue the Date for Filing of Supplemental Brief by Additional Thirty Days, ("Cont. Mot.") (ECF No. 53). Having considered the parties arguments and the law, the Court rules as follows.

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PROCEDURAL BACKGROUND

Both motions for summary judgment were initially set for hearing at 1:30 p.m. on October 20, 2016; however, on October 6, 2016 the Court vacated the hearing and requested supplemental briefing from both parties “addressing the issue whether Plaintiff Kojima or the primary insured received the relevant EOBs electronically or by United States mail or any other means.” (October 6, 2016 Order 1, ECF No. 49.) On October 19, Plaintiff submitted an *Ex Parte* Motion requesting forty-five additional days in which to file a supplemental brief because “counsel for Plaintiff ha[d] been unable to make contact or communicate with Plaintiff.” (Pl.’s *Ex Parte* Mot. to Continue the Date for Filing of Suppl. Br. by Forty-Five Days 1, ECF No. 50.) The Court granted the motion the following day. (ECF No. 50.)

Plaintiff now again requests an extension of time because “counsel for Plaintiff has remained unable to make contact or communicate with Plaintiff.” (Cont. Mot. 1.) However, Defendants have filed a Supplemental Brief that clarifies the issue on which the Court requested supplemental briefing, and Plaintiff tacitly concedes that this information should be sufficient for the Court to proceed with the pending cross-motions for summary judgment. (*Id.* at 2 (“Plaintiff reiterates that Defendants’ counsel should have evidence of whether or not BCBS of Alabama, electronically or via US mail, transmitted the relevant EOBs . . . to its participant, Patrick Kojima, or Plaintiff, its beneficiary.”); *see also id.* (“Surely, if Defendants cannot provide the answer that the Court seeks then it would not be prejudicial to the parties or to the Court to allow Plaintiff’s counsel 30 additional days to make contact with Plaintiff . . .”).) Given the foregoing, the Court **DENIES** Plaintiff’s Continuance Motion and takes the cross motions for summary judgment under submission without oral argument pursuant to Civil Local Rule 7.1(d).

FACTUAL BACKGROUND

I. Plaintiff and Her Surgical History

Plaintiff is a 54-year-old woman with a history of lower back pain who is a covered dependent under the BCBS healthcare plan at issue in this case. (Mem. of Fact and Law

1 in Supp. of Pl.’s Cross-Mot. for Summ. J. (“Pl.’s Supp.”) at 1, ECF No. 41-1; Mem. of P.
 2 & A. in Supp. of Defs.’ Mot. for Summ. J. (“Defs.’ Supp.”) at 2, ECF No. 43-1; *see* First
 3 Am. Compl. (“FAC”) ¶ 9, ECF No. 14.) Vulcan Materials Company is the Plan Sponsor
 4 and Plan Administrator, and BCBS Alabama is the claims administrator. (Defs.’ Supp. 2;
 5 FAC ¶¶ 3–4.) Because the coverage at issue was employment based, Plaintiff’s claim is
 6 governed by the Employee Retirement Income Security Act of 1974 (“ERISA”). (FAC
 7 ¶ 1; Pl.’s Supp. 1.)

8 The BCBS policy provisions relevant to this case provide that BCBS will cover up
 9 to 80% of out-of-network surgeon fees,¹ pursuant to a calculation according to the “allowed
 10 amount.” (Pl.’s MSJ Ex. B, ECF No. 42-5 at 52–53.) The allowed amount may be
 11 calculated in several ways, including by basing it on “the negotiated rate payable to in-
 12 network providers,” “the average charge for care in the area,” or “historical data and
 13 information from various sources” inclusively listed in the policy. (*Id.*, ECF No. 42-5 at
 14 83–84.)

15 From 2010 to 2013, Plaintiff underwent three surgeries administered by an out-of-
 16 network provider all attempting to fix Plaintiff’s persistent lower back pain. (Pl.’s Supp. 1.)
 17 The final two surgeries, performed by Dr. Sanjay Ghosh at his San Diego Neurological
 18 Associates facility (together, “SDNA”), were intended to diagnose and correct the initial,
 19 2010 surgery. (*See id.*) These final two surgeries—one investigatory in 2012 and one
 20 corrective in 2013—and SDNA’s corresponding services, were not reimbursed in full by
 21 BCBS and now form the basis of this suit. (FAC ¶¶ 10–15.)

22 There were several discrete charges resulting from each surgery (Pl.’s Supp. 5); each
 23 is addressed in turn according to the relevant surgery date.

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 26 ¹ An out-of-network provider is one who does not fall within the umbrella of BCBS’s “contract[s] with
 27 providers to furnish care for a negotiated price.” (Deagon Decl. Ex. A, at 46–47, ECF No. 43-2.) This
 28 often results in higher out-of-pocket expenses for plan members because, by contrast, in-network
 providers often contract with BCBS at “a discounted rate” in exchange for the peace of mind that they
 will be fully reimbursed by BCBS. (*See id.*)

1 **A. The 2012 Surgery**

2 There were three bills generated from the 2012 surgery. The billed amounts are
3 underlined, and BCBS's reimbursement payments are bolded:

- 4 (1) \$119,760.80/**\$67,199.88**—Grossmont Hospital charges (where the surgery
5 was performed), (Pl.'s MSJ Ex. B, ECF No. 42-2 at 61);
6 (2) \$62,700.00/**\$6,465.31**—Dr. Ghosh's surgical fee, (*id.*, ECF No. 42-2 at
7 62); and
8 (3) \$73,000.00/**\$1,119.79**—Felix Regala's surgical assistance fee, (*id.*, 42-2
at 64).

9 Respectively, these BCBS payments represent approximately 56.1%, 10.3%, and
10 1.5% of the total amounts billed.

11 **B. The 2013 Surgery**

12 There were two bills generated from the 2013 surgery. The billed amounts are
13 underlined, and BCBS's initial reimbursement payments² are bolded:

- 14 (1) \$26,400.00/**\$2,991.52**—Dr. Ghosh's surgical fee, (*id.*, ECF No. 42-4 at
15 91); and
16 (2) \$34,400.00/**\$370.38**—Amanda Williams's surgical assistance fee, (*id.*,
17 ECF No. 42-5 at 15).

18 Respectively, these BCBS payments represent approximately 11.3% and 1% of the
19 total amounts billed.

20 Plaintiff points out that, in total, BCBS reimbursed Dr. Ghosh and the relevant
21 surgical assistants for \$14,671.93 of the total \$129,400.00 billed—a rate of approximately
22 11.4%. (Pl.'s Supp. 11.) With the Grossmont Hospital charges added in, BCBS's total
23 reimbursements equal \$79,805.81 of the total \$316,260.80 billed—a rate of approximately
24 25.2%.

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27
28 ² BCBS actually ended up paying \$1,658.93 more in reimbursement for the two charges related to the
2013 surgery, although it is unclear why BCBS did so. (*See* Pl.'s Supp. at 8.)

II. The BCBS Explanation of Benefits/Denial Letters

Especially relevant to the pending motions for summary judgment are two aspects of the explanation of benefits (“EOB”) letters BCBS sent to Plaintiff regarding the reimbursement amounts BCBS paid for the underlying surgeries and services at issue in this case. First, all of the EOB letters that did not fully reimburse SDNA for the billed amounts used only the following language to explain BCBS’s reason for only issuing partial reimbursement:

- (1) THE SUBMITTED CHARGE EXCEEDS THE ELIGIBLE CHARGE WHICH IS THE MAXIMUM ALLOWANCE FOR THIS SERVICE.
- (2) OUR RECORDS INDICATE YOU USED AN OUT OF NETWORK PROVIDER, WHICH WILL INCREASE THE AMOUNT YOU MUST PAY OUT OF POCKET. YOU WILL OWE THE DIFFERENCE BETWEEN THE ‘SUBMITTED’ CHARGE AND THE ‘BENEFITS PAID.’

(*E.g.*, Defs.’ Suppl. Br. Exs. G, H, I, J, ECF No. 55-1.) Second, in their initial rounds of briefing Plaintiff and Defendants disagreed regarding whether the EOBs contained language advising Plaintiff of her appeal rights. (*Compare* Barker Decl., Ex. D, at 35–36, 38–39, 45–47, ECF No. 46-5, *with* Pl.’s Opp’n to Defs.’ Mot. for Summ. J. (“Pl.’s Opp’n”) 13, ECF No. 45.) Although BCBS plan members can elect to receive EOBs electronically or by regular mail, in the present case it was initially “unclear whether or not BCBS . . . sent this explanation of benefits electronically or by mail . . .” (Barker Decl. Ex. D, at 47, ECF No. 46-5.)

Defendants assert that if the EOB is sent by regular mail, then the back side of the document summarizes the member’s appeal rights. (*Id.* at 38–39, ECF No. 46-5; *see also* Deagon Decl. 4, Ex. K, ECF No. 55-1.) On the other hand, if the EOB is sent online then down “in the corner . . . [of] your computer screen, it would have a little link that says, ‘Your Rights,’” (Barker Decl. Ex. D, at 38–39, ECF No. 46-5), which, once the member clicked through, would open a new page summarizing the member’s appeal rights. Plaintiff

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1 attached to her filings copies of the online EOBs relevant to this case; notably, these EOBs
 2 neither include such a link nor otherwise mention Plaintiff's appeal rights. (*See, e.g.*, Pl.'s
 3 MSJ Ex. B, ECF No. 42-2 at 62.)

4 However, Defendants in their supplemental brief attached: (1) a supplemental
 5 declaration by Jan B. Deagon, "Customer Services Manager for BCBS Alabama" during
 6 the time period relevant to this litigation; and (2) copies of the EOBs relevant to this action
 7 which were maintained "in the books and records of BCBS Alabama" (Deagon Decl.
 8 ¶¶ 1, 6, Exs. G, H, I, J, ECF No. 55-1; *see also id.* Ex. K.) Declarant Deagon notes that
 9 "neither Patrick Kojima nor Vablin Kojima . . . ever registered for the 'My Blue Cross'
 10 electronic access to information portal with BCBS Alabama, so BCBS Alabama does not
 11 have an email address for either of them." (*Id.* ¶ 3.) This means that "all documents
 12 communicated to [the Kojimas] by BCBS Alabama" were necessarily "mailed via regular
 13 U.S. Postal Service mail, to the following address: Patrick Kojima[,] 1668 Toledo Way,
 14 #2[,] Chula Vista CA 91913" (*Id.*) This assertion is further substantiated by the
 15 attached EOBs, which each list this same California address near the top. (*Id.* Exs. G, H,
 16 I, J.) And, as Defendants previously noted, each mailed EOB contained a section on its
 17 back side outlining Plaintiff's appeal rights. (*Id.* Ex. K (form language); *id.* ¶ 8 ("[T]he
 18 pre-printed language in Exhibit 'K' was on the back side of all four Processed Claim Report
 19 forms BCBS Alabama mailed to Patrick Kojima").)

20 **III. The Provider Appeals to BCBS**

21 BCBS recognizes two discrete types of appeals: (1) member appeals, and (2)
 22 provider appeals. Member appeals—labeled "an appeal of an adverse benefit
 23 determination" in the BCBS member policy materials—are explained at length in the
 24 BCBS policy materials. The appeals section of the BCBS policy materials note that only
 25 the member or an authorized representative, who must be so authorized in writing by the
 26 member, may validly appeal an adverse benefit determination. (Pl.'s MSJ Ex. B, ECF No.
 27 42-5 at 72–74.) For an appeal to be valid it must be filed within 180 days and submitted
 28 in writing to BCBS of Alabama. (*Id.*, ECF No. 42-5 at 73.) The policy further provides

1 that if an inquiry labeled as an appeal is submitted “without following the rules just
2 described for filing an appeal” then BCBS “will not treat your inquiry as an appeal.” (*Id.*,
3 ECF No. 42-5 at 72.)

4 Separate and apart from member appeals, Defendants assert that provider appeals—
5 never mentioned in the BCBS member policy materials—are “a courtesy offered to
6 providers” and do not fall under ERISA’s provisions. (Deagon Dep. 13, ECF No. 46-5.)
7 BCBS alleges that providers must appeal their reimbursement rates—a provider appeal—
8 to their local arm of BCBS, and must appeal their reimbursement rates on behalf of the
9 member—a member appeal, if the provider is so authorized to act on behalf of the
10 member—to the BCBS arm that issued the member’s policy. (*See id.* at 17.) Members
11 must always appeal to the BCBS arm that issued their policy. (*See id.*) Finally, the policy
12 notes that the member “cannot file a claim for benefits under the plan in federal or state
13 court (or in arbitration if provided by your plan) unless you exhaust these administrative
14 remedies.” (*Id.* at 35.)

15 SDNA submitted several letters to BCBS of California, each entitled in part
16 “APPEAL FOR VABLIN Y. KOJIMA,” then stating that “[t]his appeal is for SD[NA],”
17 and ultimately “request[ing] that you reconsider the claim for additional payment to
18 SD[NA].” (*Id.* Pl.’s MSJ Ex. A, ECF No. 42-1 at 17, 23, 28.) On April 3, 2013—sixty-
19 two days after BCBS issued the relevant EOB—SDNA submitted to BCBS two letters
20 requesting that BCBS reconsider the reimbursement amounts given to Dr. Ghosh and Ms.
21 Regala, respectively, for the 2012 surgery. (*Id.* Ex. B, ECF No. 42-4 at 47.) BCBS of
22 California responded to SDNA forty-three days later, acknowledging receipt of SDNA’s
23 earlier letters and stating that “the inquiry has been sent for medical review for possible
24 additional consideration.” (*Id.* Ex. A, ECF No. 42-1 at 27.) This was the last
25 communication to either Plaintiff or SDNA regarding these appeals. On August 29,
26 2013—twenty-three days after BCBS issued the relevant EOB—SDNA submitted to
27 BCBS a request that BCBS reconsider the reimbursement amount given to Mrs. Williams
28 for the 2013 surgery. (*Id.* Ex. B., ECF No. 42-4 at 74.) On September 10, 2013—thirty-

four days after BCBS issued the relevant EOB—SDNA submitted to BCBS a request that BCBS reconsider the reimbursement amount given to Dr. Ghosh for the 2013 surgery. (*Id.*, ECF No. 42-4 at 61, 84.) Neither SDNA nor Plaintiff received any communication regarding these requests.

However, BCBS internal memoranda discloses internal communications regarding Plaintiff's surgery and SDNA's requests. (*E.g., id.*, ECF No. 42-3 at 8, 55; ECF No. 42-4 at 4, 8, 11, 25, 27, 43, 57, 59, 67, 70, 92; ECF No. 42-5 at 1.) These communications included, among others: (1) a note that "this is a provider appeal not a sub appeal" with a corresponding request to "verify since this is a provider appeal that the allowed amounts provided were correct," (*id.*, ECF No. 42-4 at 57); (2) an inquiry marked "Blue2 Claim Appeal" by "Provider on Behalf of Member" with a corresponding answer that "this is a professional reimbursement issue and is not handled by BCBSAL," (*id.*, ECF No. 42-4 at 70); and (3) a note responding to an inquiry on behalf of the primary insured—Mr. Kojima—noting that Mr. Kojima requested "status on claim appeal for svcs on 6/13 . . . [because] he ha[d] not rec'd a resp yet and the prov has not rec'd a resp," and replying to relevant BCBS employees requesting they "advs the appeals on file and refund req on file are for DOS 12/6/12," (*id.*, ECF No. 42-5 at 1).

LEGAL STANDARD

Under Federal Rule of Civil Procedure 56(a), a party may move for summary judgment as to a claim or defense or part of a claim or defense. Summary judgment is appropriate where the Court is satisfied that there is "no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(a); *Celotex Corp. v. Catrett*, 477 U.S. 317, 322 (1986). Material facts are those that may affect the outcome of the case. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986). A genuine dispute of material fact exists only if "the evidence is such that a reasonable jury could return a verdict for the nonmoving party." *Id.* When the Court considers the evidence presented by the parties, "[t]he evidence of the non-movant is to be believed, and all justifiable inferences are to be drawn in his favor." *Id.* at 255.

1 The initial burden of establishing the absence of a genuine issue of material fact falls
 2 on the moving party. *Celotex*, 477 U.S. at 323. The moving party may meet this burden
 3 by identifying the “portions of ‘the pleadings, depositions, answers to interrogatories, and
 4 admissions on file, together with the affidavits, if any,’” that show an absence of dispute
 5 regarding a material fact. *Id.* When a party seeks summary judgment as to an element for
 6 which it bears the burden of proof, “it must come forward with evidence which would
 7 entitle it to a directed verdict if the evidence went uncontroverted at trial.” *See C.A.R.*
 8 *Transp. Brokerage Co. v. Darden Rests., Inc.*, 213 F.3d 474, 480 (9th Cir. 2000) (quoting
 9 *Houghton v. South*, 965 F.2d 1532, 1536 (9th Cir. 1992)).

10 Once the moving party satisfies this initial burden, the nonmoving party must
 11 identify specific facts showing that there is a genuine dispute for trial. *Celotex*, 477 U.S.
 12 at 324. This requires “more than simply show[ing] that there is some metaphysical doubt
 13 as to the material facts.” *Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574,
 14 586 (1986). Rather, to survive summary judgment, the nonmoving party must “by her own
 15 affidavits, or by the ‘depositions, answers to interrogatories, and admissions on file,’
 16 designate ‘specific facts’” that would allow a reasonable fact finder to return a verdict for
 17 the non-moving party. *Celotex*, 477 U.S. at 324; *Anderson*, 477 U.S. at 248. The non-
 18 moving party cannot oppose a properly supported summary judgment motion by “rest[ing]
 19 on mere allegations or denials of his pleadings.” *Anderson*, 477 U.S. at 256.

20 ANALYSIS

21 Plaintiff in her MSJ puts forth solid arguments both that BCBS’s reimbursement
 22 rates were unreasonable under any calculation and that BCBS’s two separate appeals
 23 processes—an explanation of which appears nowhere in BCBS literature—could easily
 24 confuse a BCBS subscriber into thinking his provider is appealing on his behalf.³ However,
 25 _____

26 ³ Plaintiff also argues (1) that the relevant EOBs do not comply with ERISA regulations due to lack of
 27 sufficient specificity in the provided reasons for denial of Plaintiff’s reimbursement requests, and (2) that
 28 BCBS had a duty to assume SDNA’s appeals were on behalf of Mrs. Kojima and
 therefore also “had an affirmative obligation to point this out to Mrs. Kojima and inform her of what was
 necessary to perfect her appeal.” (Pl.’s Supp. 20.) As discussed in Section I, *infra*, the Court need not

1 because Defendants argue the BCBS policy provisions explicitly require a subscriber to
 2 exhaust administrative remedies before filing suit in federal court, and because if Plaintiff
 3 did not here exhaust her administrative remedies this suit is improperly before this Court,
 4 the Court first addresses this threshold jurisdictional issue.

5 **I. Failure to Exhaust Administrative Remedies**

6 In the present case, the controlling Vulcan and BCBS policy clearly states that a
 7 member “cannot file a claim for benefits under the plan in federal or state court . . . unless
 8 [the member] exhaust[s] . . . administrative remedies.” (Deagon Decl. 35, ECF No. 43-4.)
 9 Exhaustion under the plan requires that a member or an authorized representative, who
 10 must be so authorized in writing by the member, appeal an adverse benefit determination
 11 by conforming to the requirements of (1) writing (2) to BCBS of Alabama (3) within 180
 12 days of the underlying adverse benefit determination. (*Id.* at 73.) The policy further
 13 provides that if an inquiry labeled as an appeal is submitted “without following the rules
 14 just described for filing an appeal” then BCBS “will not treat your inquiry as an appeal.”
 15 (*Id.* at 72.)

16 Both Plaintiff and Defendants seemingly agree that Ms. Kojima did not herself
 17 appeal. (*See* Pl.’s Opp’n 5–6; Defs.’ Reply 2–3.) Given this, Plaintiff argues that because
 18 it is “standard practice for medical providers to initiate appeals on their patients [sic]
 19 behalf” the SDNA appeals should have been treated as member appeals despite Plaintiff’s
 20 admission that “Ms. Kojima . . . failed to comply with the requirement . . . that she first fill
 21 out the proper form.” (Pl.’s Opp’n 19.) However, both the language of the BCBS policy
 22 and the Department of Labor (“DOL”) regulations specify that only an authorized
 23 representative may bring such an appeal, (*see* 29 C.F.R. § 2560.503-1(b)(4)), and to
 24 designate an authorized representative under the BCBS policy requires a written
 25 authorization by the member. Because in the present case Plaintiff did not by writing
 26

27 reach this argument due to Plaintiff’s failure to exhaust her administrative remedies. Further, even if
 28 Plaintiff did succeed on these additional arguments the Court would be unable to award the substantive
 remedy Plaintiff requests. *See* note 4, *infra*, and accompanying text.

1 authorize SDNA to act on her behalf, Plaintiff's contention here fails.⁴ Plaintiff thus failed
2 to exhaust her administrative remedies before filing suit in federal court.

3 However, failure to exhaust administrative remedies may in some instances be
4 forgiven. DOL regulations regarding ERISA require plan administrators, upon issuing any
5 adverse benefit determination, to provide written notice to the claimant of:

- 6
- 7 (1) The specific reason for the denial;
 - 8 (2) Specific reference to the pertinent plan provisions on which the denial is
9 based;
 - 10 (3) A description of any additional material or information necessary for the
11 claimant to perfect the claim and an explanation of why such material or
12 information is necessary; and
 - 13 (4) Appropriate information as to the steps to be taken if the participant or
14 beneficiary wishes to submit his or her claim for review.

15 29 C.F.R. § 2560.503-1(f). Specifically, when an adverse benefit determination “fails to
16 explain the proper steps for appeal, the plan’s time bar is not triggered.” *See White v.*
17 *Jacobs Eng’g Grp. Long Term Disability Benefit Plan*, 896 F.2d 344, 350 (9th Cir. 1989).⁵

18 ⁴ Plaintiff argues that not once did BCBS indicate to the Kojimas that the SDNA appeals were being
19 treated as provider rather than member appeals and notes that “[i]t would have been the simplest thing for
20 someone at BCBS of Alabama to have mentioned, even in passing, that [Plaintiff] needed to fill out its
21 form in order to have the appeals considered.” (Pl.’s Opp’n 20.) This may well be true, and the Court is
22 indeed troubled by the internal BCBS communication on August 22, 2014 noting that Mr. Kojima inquired
23 about the “status on claim appeal for svcs on 6/13 . . . [because] he ha[d] not rec’d a resp yet and the prov
24 has not rec’d a resp” (Pl.’s MSJ Ex. B, ECF No. 42-5 at 1). This would seem to indicate that at least
25 one BCBS employee had notice that the Kojimas might have thought SDNA’s appeals applied to them as
26 well. However, the language of both the relevant policy and the EOB Appeals Sections were clear
27 regarding all of the requirements to appeal an adverse benefit determination, including that any
28 designation to an authorized representative had to be in writing. (*E.g.*, Defs.’ Suppl. Br. Ex. K, ECF No.
29 55-1). Accordingly, while the employees involved in the August 22, 2014 communication may have acted
30 harshly, BCBS’s EOBs and appeals policy both comply with relevant ERISA provisions.

31 ⁵ This appeals-rights-specific holding could arguably be expanded to encompass any inadequate notice,
32 including technical, rather than substantive, violations of the relevant ERISA provisions. *See White*, 896
33 F.2d at 350 (labeling opinion’s Section III—containing the above-quoted holding—as “Inadequate notice
34 did not trigger the 60-day time bar” and Section III immediately following the previous section’s
35 description of all the ways in which the notice at issue was inadequate). However, such an expansion
36 would almost certainly run afoul of a separate strand of Ninth Circuit case law. *See, e.g., Hancock v.*
37 *Montgomery Ward Long Term Disability Tr.*, 787 F.2d 1302, 1308 (9th Cir. 1986) (“Substantive remedies

1 This comports with the Ninth Circuit’s general view regarding ERISA and the
 2 corresponding DOL regulations as requiring “a meaningful dialogue between ERISA plan
 3 administrators and their beneficiaries.” *Booton v. Lockheed Med. Benefit Plan*, 110 F.3d
 4 1461, 1463 (9th Cir. 1997).

5 Accordingly, in the present case the Court may validly consider Plaintiff’s claims if
 6 BCBS’s notice to Plaintiff of her appeal rights was deficient. Prior to the supplemental
 7 briefing the record was both too ambiguous and too sparse for the Court to render a decision
 8 on this issue. Defendants claimed that the EOBs “sent to plaintiff’s spouse, the plan
 9 participant, included notification about plaintiff’s appeal rights. As part of the EOB form,
 10 on the back side of the hard copy sent to the member, a page describing member’s appeal
 11 rights was produced and testified about [(Exhibit 11)].” (Defs.’ Opp’n 8 (emphasis
 12 added).) Contrastingly, Plaintiff claimed that “the Exhibit 11 form is actually describing
 13 some other type of EOB than the ones sent to Ms. Kojima,” and notes that the online EOBs
 14 in Plaintiff’s disclosures “do not appear to be incomplete; they each state how many pages
 15 they include, and all the pages are accounted for in the Record” (Pl.’s Reply 4.)
 16 Further underscoring this conflict, the witness introducing Exhibit 11 was asked whether
 17 in the present case “BCBS of Alabama sent t[he relevant] explanation of benefits
 18 electronically or by mail” and responded that “[i]t was sent one way or the other, but I
 19 don’t know which way without referring to the contract.” (Deagon Dep. 47.)

20 However, Defendants’ Supplemental Brief has now resolved this factual dispute. As
 21 noted above, Defendants attached to their Supplemental Brief both the specific EOBs—

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 24 are available for procedural defects under ERISA only when the defects ‘caused a substantive violation
 25 or themselves worked a substantive harm.’” (citing *Ellenburg v. Brockway, Inc.*, 763 F.2d 1091, 1096 (9th
 26 Cir. 1985)); *Parker v. BankAmerica Corp.*, 50 F.3d 757, 768 (9th Cir. 1995) (noting that “[o]rdinarily, a
 27 claimant who suffers because of a fiduciary’s failure to comply with ERISA’s procedural requirements is
 28 entitled to no substantive remedy” (citing *Blau v. Del Monte Corp.*, 748 F.2d 1348, 1353 (9th Cir. 1984),
cert. denied, 474 U.S. 865 (1985))). Thus, although in the present case Plaintiff’s MSJ could be correct
 that the BCBS EOBs’ cursory reasoning behind the adverse benefits determinations was inadequate under
 ERISA, it would be hard if not impossible to find substantive harm for this procedural violation given that
 Plaintiff did not appeal those determinations.

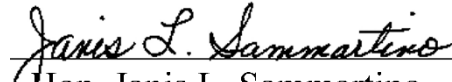
1 rather than merely form EOBs—sent to Plaintiff, and the Deagon Declaration verifying
2 that Plaintiff had not signed up for electronic receipt of the EOBs. This leaves regular U.S.
3 Postal Service mail as the only possible way by which the Kojimas could have received
4 the EOBs, a conclusion that is bolstered by the inclusion of the Kojimas' mailing address
5 at the top of each relevant EOB. Further, because each mailed EOB had specific
6 information regarding Plaintiff's appeal rights, there is no longer any genuine issue of
7 material fact concerning whether BCBS's EOBs complied with the ERISA requirements
8 concerning notice and explanation of an insured's appeal rights—they did.

9 CONCLUSION

10 Given the foregoing, the Court concludes that Plaintiff failed to exhaust her
11 administrative remedies, as required by the BCBS plan, and is thus barred from bringing
12 suit in federal court. Accordingly, the Court **GRANTS** Defendants' Motion for Summary
13 Judgment and **DENIES AS MOOT** Plaintiff's Motion for Summary Judgment.

14 IT IS SO ORDERED.

15 Dated: December 8, 2016


16 Hon. Janis L. Sammartino
17 United States District Judge
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